JACC Vol. 12, No. 5
November 1988:1386–7

ACC NEWS

President's Page: You Can Tell a Cardiologist by the CPT Code

ANTHONY N. DEMARIA, MD, FACC

President, American College of Cardiology

The typical busy cardiovascular specialist is confronted daily by many difficult decisions. From the medical standpoint, the cardiologist must frequently decide whether to apply thrombolytic therapy, to perform cardiac catheterization, to recommend bypass surgery or pacemaker implantation and whether to employ antiarrhythmic or vasodilator drugs. Regarding the delivery of care itself, physicians often grapple with issues relating to the optimal technology to be utilized in their office or hospital and which procedures they have obtained adequate expertise to perform. It is not surprising, therefore, that amid the multiple important daily issues cardiologists face, little attention is paid to the Current Procedural Terminology (CPT) codes under which their services are billed.

CPT-4 and cardiovascular imaging techniques. The Physicians' Current Procedural Terminology–4th Edition (CPT-4) handbook, published by the American Medical Association in 1988, consists of a systematic listing and coding of procedures and services performed by physicians. Procedures and services are classified into five major sections: medicine, anesthesiology, surgery, radiology, and pathology and laboratory. Listings generally are grouped by organ system within each major section. Of significance to cardiologists is the fact that many cardiovascular services, specifically those employing imaging techniques, are listed twice, once under medicine (CPT codes in the 90,000s) and once under radiology (CPT codes in the 70,000s). Recently, the CPT-4 codes used for billing have assumed great importance for clinical cardiologists.

Defining a radiologist. The Omnibus Budget Reconciliation Act signed into law in 1987 provided for the construction of a relative value scale to serve as the basis for Medicare payment for radiologic services. In entering into this agreement, radiologists opted for the potential of a discounted fee schedule rather than alternative reimbursement schemes such as diagnosis-related group categories (DRGs). Of particular relevance to cardiologists is the fact that, for the purposes of this legislation, radiologic services were defined as those provided by a physician eligible or certified by the American Board of Radiology or "for whom radiologic services account for at least 50% of billing" under Part B of Medicare. Therefore, this legislation created the possibility that certain cardiologists who deal extensively with procedures employing imaging, such as cardiac catheterization, radionuclide studies or ultrasound, could be classified as radiologists. In addition to representing a clearly inappropriate classification, such a definition could have resulted in a situation in which cardiologists were bound to a financial agreement with the Medicare program that they had no role in negotiating.

The American College of Cardiology has expressed concern about this legislative provision, particularly about the definition of a radiologist. In a written response to the Health Care Finance Administration (HCFA) the College pointed out that many procedures employing imaging technologies are cardiovascular services performed by cardiologists. These procedures typically require expertise in both cardiocirculatory physiology and pathophysiology in addition to a knowledge of anatomy. The primacy of the cardiovascular domain of these procedures is supported by the contributions of cardiologists to the development and validation of the technology as well as by the fact that the majority of procedures are performed by cardiologists. In a letter to William Roper, MD, Administrator of HCFA, I expressed the concern of the College that this legislation might result in the inappropriate and, we believe, unintentional consequence of having organized radiology directly negotiate a fee schedule for cardiovascular specialty services.

The CPT-4 solution. From the outset it appeared that the straightforward solution to this dilemma lay in the CPT-4 code book. This reference guide, which was developed with representation from all specialties of medicine, recognizes

Address for reprints: Anthony N. DeMaria, MD, Division of Cardiology, University of Kentucky Medical Center, 800 Rose Street, Lexington, Kentucky 40536.

0735-1097/88/$3.50

the separate and distinct nature of the imaging services in the area of cardiology and radiology. Because separate cardiovascular and radiologic codes are listed for cardiovascular procedures that employ imaging, a method exists by which to distinguish those services provided by cardiologists and radiologists. Indeed, in a recent public statement, Dr. Ross Anthony, the Assistant Administrator for policy of HCFA, indicated the intent of his office to focus on the radiologic 70,000 series CPT-4 codes in the construction of the forthcoming radiology fee schedule. Thus it appears that a resolution of this potential problem is at hand.

Billing for cardiovascular services under the 90,000 series CPT-4 codes. In the course of gathering data and communicating with government representatives involved in the development of the radiology relative value scale, several important issues have appeared. There are data indicating that a considerable percentage of radiologic services is billed by nonradiologists (up to 35% in one survey). Evidence exists suggesting that many cardiologists bill for services under the radiologic CPT-4 codes and that cardiologists may well account for a large portion of reimbursement requests submitted by nonradiologists. Clearly, billing for a cardiologist's services under radiologic CPT-4 codes has implications in several areas, including the collection of health care statistics and determining the relative prominence various specialties play in the delivery of specific services and procedures. Such considerations may be too abstract to have a significant impact on the busy cardiologist. However, the attention of even the most harried among us should be attracted by the fact that cardiovascular services billed under radiologic CPT-4 codes will likely be reimbursed at a different level—one negotiated by radiologists—after implementation of the new radiology relative value scale.

Accordingly, it is imperative that each cardiologist ensure that requests for reimbursement for all services and procedures are appropriately submitted under the 90,000 series CPT-4 codes for cardiovascular services. For better or for worse, it appears that in the future the government will recognize cardiologists largely on the basis of the CPT-4 codes they utilize.